Therapist Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____
Fax: _____
Email: _____

Billing Statement©

Invoice Number: _____
Invoice Date: _____
Bill To: Center for Physical Therapy Services, Inc.

Eval Rate: _____ **Tx Rate:** _____

Patient Name/Agency Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Eval's	Tx's
1																																	
2																																	
3																																	
4																																	
5																																	
6																																	
7																																	
8																																	
9																																	
10																																	

E = Evaluation
T = Treatment
D = Discharge

C = Communication
D = Discharge without Visit
R = Re-Evaluation (30 Days or 13th Visit or 19th Visit)

Total Eval's: _____ **X Eval Rate:**
Total Tx's: _____ **X Tx Rate:**
Total Due:

Center for Physical Therapy Services, Inc. reserves the right to deduct from ones invoice based on: (1) Notes that are late greater than 7 Calendar Days; (2) Incomplete Notes; (3) Notes that do not comply with the therapy frequency; (4) Notes that are returned to our office from the respective home health agencies. Ensure that you have all of your credentials up to date, otherwise payments may be delayed.